

Certification Statement for Providers Submitting Claims

This is to certify that any and all information contained on any Medicaid or Children's Health Insurance Program (CHIP) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary, or service bureau that submits billings to the Family and Social Services Administration (FSSA) or its Fiscal Agent Contractor is acting as my representative and not that of FSSA or its Fiscal Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of Medicaid and CHIP claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from Federal and State funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and/or State law. The provider will hold harmless and indemnify FSSA from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of Medicaid or CHIP billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of FSSA.

I acknowledge that the fees and charges paid to providers for all medical services rendered or materials supplied shall be in accordance with Federal and State law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of the Indiana Health Coverage Programs, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by either the Indiana Health Coverage Programs Fiscal Agent Contractor, or the Indiana Health Coverage Programs Rate Setting Contractor.

I further certify that no supplemental charges will be billed to any Indiana Health Coverage Programs member or to the family of any member for any covered service of the Indiana Health Coverage Programs, except for copayment, patient liability payments, and any other patient payments as required by law.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the Indiana Health Coverage Programs, and to furnish such information regarding any Medicaid or CHIP payments claimed for providing such services to FSSA or its designee, upon request, for a period not less than three years from the date of service, or any such period FSSA may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by FSSA or its Fiscal Agent Contractor. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to its Fiscal Agent Contractor for claims payment, to document the accuracy of the service for which I have billed the Indiana Health Coverage Programs. I agree to submit such records as may be required by FSSA or the Federal Government.

I understand that FSSA or its designees are prepared to provide necessary technical assistance to assist new providers, or to correct technical problems which existing providers may experience. I realize that all communications regarding electronic, telephonic, mechanical, or standard paper submission of claims shall be between the provider in whose name the claim is submitted and FSSA or its Fiscal Agent Contractor. I further understand that this technical assistance shall consist of:

- Identification of data element requirements
- Identification of record layouts and other electronic specifications
- Identification of systematic problem areas and recommended solutions

I agree to execute a separate Certification Statement for each Indiana Health Coverage Programs (IHCP) provider number that has been issued to me. I also agree to notify either FSSA or its Fiscal Agent Contractor of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission as may be required by FSSA or its Fiscal Agent Contractor.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the even that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

I recognize that any difference of opinion concerning the amount of Indiana Health Coverage Programs payment for any claim must be adjudicated as provided in Indiana Code 4-21.5-3. Further I understand that violation of any of the provisions of this Certification Statement shall subject me to the sanctions set out in Indiana Code 12-15-22-1 and shall make the billing privilege established by this document subject to immediate revocation at FSSA's option.

THE UNDERSIGNED HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY DOES HEREBY AGREE TO ALL OF THE STIPULATIONS, CONDITIONS AND TERMS STATED HEREIN.

Provider Name

Title

Provider Signature

Date

IHCP Provider Number/Service Location